STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) ensure that washed utensils were dried in a manner to prevent contamination from foreign substances and potential for the development of food-borne illness; b.) maintain the kitchen equipment in a sanitary manner to prevent microbial growth; c.) store, label and date potentially hazardous foods to prevent food borne illness; and d.) ensure bottled drinking water supply was stored in a sanitary manner at least six inches from the floor. This deficient practice was evidenced by the following:On 9/11/2025 at 9:08 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and observed the following:1. Near the washing area, dinner knives, forks, and teaspoons contained in perforated plastic flatware containers being air-dried by a standing fan with dust build-up at the back grills. The FSD stated that the fan was cleaned the previous night. 2. Manual can opener blue plastic slide bar insert with heavy buildup of blackish unidentified substance. A staff member handed the clean blade and stem to the FSD who reassembled the parts together. The FSD stated that they could not clean the blue plastic insert, so they ordered a new one to come in.On 9/12/2025 at 8:48 AM, the surveyor toured the first-floor pantry with Registered Nurse/ Unit Manager (RN/Um #1) and observed the following:1. Reach-in refrigerator freezer without an internal thermometer. Six cups of ice cream were observed inside. RN/UM #1 stated that there used to be a thermometer inside the freezer. 2. Reach-in refrigerator contained an unlabeled and undated chicken soup in a covered Pyrex container. The surveyor also observed an undated box of 2 cannoli and box of 2 puff pastries. On 9/17/2025 at 8:30 AM, the surveyor observed the following in the hallway near the kitchen:1. Three 5-gallon jug water containers inserted horizontally inside blue plastic crates which were in direct contact with the floor. The mouthpiece up to the neck part of the containers were [NAME] out of the crates exposed to any activity on the floor. The crates were observed to have heavy buildup of dirt and dust. The FSD stated the water jugs should not be there, and they will be relocated. A review of facility-provided undated policy titled General Sanitation of Kitchen did not address proper drying of utensils.A review of facility-provided procedure dated 3/22/2024 titled Can Opener Cleaning Instructions included the following: 5. Take out blue holding block. Wash, rinse, and sanitize.A review of facility provided policy dated 12/15/2024 titled Dating and Labeling Policy included the following: All . food otherwise stored outside their original containers, must be labeled and dated at the time it was put in the container. The label must include the item description, the date stored, opened date and the use by date.A review of facility-provided policy dated 2/3/2024 titled Food Storage Policy and Procedure did not include proper storage of water containers. N.J.A.C. 8:39 - 17.2 (g)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, review of medical record and pertinent facility documentation, it was determined that the facility failed to a.) provide residents with appropriate products for hand hygiene during mealtime identified in 2 of 3 dining room observations (1st floor Tea [NAME] and the Main dining rooms) and b.) implement and maintain a resident with stage 3 pressure ulcer wound on Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes identified in 1 of 1 resident (Resident #114) reviewed for pressure ulcer, to prevent the potential spread of infection in accordance with the Center for Disease Control and Prevention (CDC) guidelines and standards of infection control practice. This deficient practice was evidenced by the following: Reference: Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html Reference: Enhanced Barrier Precautions are indicated for residents known to be colonized or infected with an MDRO deemed novel or targeted by the CDC. When Contact Precautions do not otherwise apply, or when the resident has an indwelling medical device or wound. https://www.nj.gov/health/cd/documents/topics/hai/EBP_in_Nursing_Homes_Algorithm.pdf 1.(a) On 09/12/2025 at 11:38 AM, Surveyor #1 observed dining for lunch on the 1st floor Tea [NAME] dining room. The Assistant Activities Director (AAD) provided the residents in the dining room with lemon-scented moist towelettes for hand hygiene. The lemon-scented moist towelettes were alcohol free. During an interview with Surveyor #1 on 09/12/2025 at 11:50 AM, the AAD stated that the lemon-scented moist towelettes are what the facility uses to provide hand hygiene for residents prior to meals. During an interview with Surveyor #1 on 09/15/2025 at 12:35 PM, the Infection Preventionist (IP) stated that the facility provides towelettes scented with lemon to residents during mealtimes. She further stated that she was unsure whether the towelettes contain alcohol. During an interview with Surveyor #1 on 09/16/2025 at 1:10 PM, the Assistant Licensed Nursing Home Administrator (ALNHA) stated that lemon-scented moist towelettes are currently used by the facility to provide hand hygiene for residents prior to meals. She also stated that the facility plans to purchase alcohol-based hand wipes in the future for resident use. A review of a facility policy dated 05/06/2025 titled, Resident Health Program, revealed that, An active Resident Health Program is maintained as part of the overall Infection Control Program of the facility, under the direction of the Infection Control Committee and supervised by the Infection Control Coordinator. Educate resident on proper hand hygiene which includes washing hands with soap and water, utilizing alcohol-based sanitizer rub and to utilize the wipes that are provided with meals. b.) On 9/15/2025 at 11:45 AM, Surveyor #2 observed residents for lunch meal service in the Tea (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[NAME] dining room. A total of 17 residents occupied 6 of 11 tables in the dining room. The surveyor observed Helping Hand (HH) staff and Certified Nursing Assistant (CNA #1) assist residents wipe their hands using lemon-scented moist towelette packs before eating lunch. HH stated to this surveyor that the towelettes were the only supplies they use to clean the residents' hands before meals. On 9/16/2025 at 1:10 PM, during an interview with the survey team, the ALNHA stated that the lemon-scented moist towelettes are currently used by the facility to provide hand hygiene for residents prior to meals. They also stated that the facility plans to purchase alcohol-based hand wipes in the future for resident use. 2.) On 9/11/2025 at 10:46 AM, the Surveyor #2 observed Resident #114 in bed. The resident was using a low-air loss type of mattress. There was no signage for EBP inside and outside the room. No Personal Protective Equipment (PPE) supplies were immediately available near the room. On 9/12/2025 at 9:29 AM, the surveyor observed Resident #114 in bed. There was no signage for EBP inside or outside the room. No PPE supplies were immediately available near the room. On 9/16/2025 at 10:00 AM, the surveyor observed the resident's sacral wound treatment by Licensed Practical Nurse (LPN #1). LPN #1 wore gloves but did not wear any protective gown throughout the wound treatment process. The surveyor asked LPN #1 if they should have used a gown during the wound treatment. LPN #1 stated that since there was no sign that the resident was on EBP along the doorway, they did not wear the gown. The surveyor reviewed the electronic medical record (EMR) for Resident #114. A review of the Resident Face Sheet (an admission record) reflected the resident was admitted to the facility with diagnoses which included stage 3 pressure ulcer of the sacral region (a type of wound that develops over the tail bone area due to prolonged pressure) and malnutrition. A review of the most recent comprehensive Minimum Data S (MDS), an assessment tool dated 7/23/2025, indicated that the resident had no unhealed pressure ulcer. A review of the physician orders as of 9/5/2025, included the following treatment orders: Clean sacral wound with NSS (normal saline solution), apply Manuka honey ointment, and cover with CDD (conventional dry dressing). A review of the comprehensive person-centered care plan revealed a focus for actual skin impairment with the following interventions: Maintain adequate nutrition, position with pads to prevent pressure and offload affected area, wound consult, wound treatment, and wound healing supplement as ordered. On 9/16/2025 at 11:22 AM, during an interview with the survey team, the Director of Nursing (DON) stated that the EBP process entailed the staff use of gown and gloves during high-contact activities like wound care for residents with medical devices and wounds. A review of facility-provided undated policy titled Enhanced Barrier Precautions included under Policy: . Enhanced Barrier Precautions (EBP) are an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus (a bacteria) and MDROs. The policy also included under Overview: 3.) EBP may be applied (when Contact Precautions (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization, and infection or colonized with an MDRO. N.J.A.C. 8:39 - 19.4 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, review of electronic medical records (EMR) and other pertinent facility documentation it was determined that the facility failed to document non-pharmacological interventions to manage a resident's behavior prior to administration of psychotropic medications. This deficient practice was identified for 1 of 5 residents (Resident #37) reviewed for unnecessary medications and was evidenced by the following:Review of the resident Face Sheet (admission summary) indicated that Resident #37 was admitted to the facility with the diagnoses that included but was not limited to dementia with other behavior disturbance, anxiety disorder, hypothyroidism and hypertension.Review of the quarterly Minimum Date Set (MDS) an assessment tool that facilitates a resident's care dated 8/15/25, indicated that Resident #37 had short and long-term memory deficits and was severely impaired with decision making. The MDS also indicated that the resident required moderate assistance with activities of daily living and exhibited no behaviors.On 9/11/2025 at 11:15 AM, the surveyor observed Resident #37 sitting quietly in the hallway in front of the nurse's station. The resident was in no distress, clean and dressed appropriately. The resident was unable to be interviewed due to cognitive deficits.On 9/12/2025 at 10:22 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that Resident #37 required assistance with washing and dressing. She also stated that resident was confused and required assistance with tray set up but was able to feed themselves. She stated that the resident did not have behaviors that she was aware of. On 9/12/2025 at 10:27 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #37 was confused and required supervision and direction. She stated that the resident sundown's (a period of increased confusion, agitation, and behavioral changes that often occurs in the late afternoon and evening in people with dementia) and paces the hallways at times in the wheelchair. She explained that the resident was redirected with guiding, food and toileting and that the resident required Xanax (antianxiety medication) at times due to being restless, yelling and trying to stand up. She stated that the resident did not listen when pacing and did not come back when asked by staff members. She stated that the resident was given a Xanax but not all the time. The LPN continued to add that the staff would try to bring the resident to activities, but the resident would sometimes not participate. On 9/12/2025 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manage (LPN/UM) who stated that Resident #37 had confusion and was very calm in the morning but restless in the afternoon and early evening. She stated that the resident paced in the wheelchair and usually a staff member would have to sit with the resident. She said that staff would sometimes just let the resident pace or that the activities department would try to read with the resident. She also added that activities department would take the resident outside, provide snacks and have the resident fold clothes. She explained that the psychiatrist saw the resident on 7/9/25 and started the resident on the psychotropic medication Zoloft for the restlessness. She stated that the antianxiety medication Xanax was only ordered for 14 days until the Zoloft could get into the resident's system. Review of the psychiatrist consultation dated 7/9/25, indicated that the nurses stated that Resident #37 was having episodes of increased anxiety, restlessness and frequently trying to stand up especially after dinner. The psychiatrist indicated that the resident was having no signs or symptoms of depression or anxiety at that time, however, was seen in the early morning hours and staff and family had reported increased anxiety occurred in the afternoon after dinner. The psychiatrist recommended starting Sertraline (Zoloft) 25 mg one tablet at bedtime for anxietyThe surveyor reviewed the physician's orders dated 7/9/25 for Sertraline (Zoloft) 25 mg one tablet at bedtime for anxiety.Review of the progress notes prior to the start date of Zoloft of 7/9/25, revealed that there was no documented behavior nor were there interventions documented regarding non-pharmacological interventions to manage behaviors such as agitation, pacing, or wandering or standing from the wheelchair. There was also no behavior monitoring documented after the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication Zoloft was administered.Review of the Interdisciplinary Care Plan (ICP) revealed that there was a ICP dated 5/12/25, with the focus on Dementia. There were no resident specific interventions to demonstrate how the facility was managing the resident's dementia. The interventions included the following: Use simple words or instructions. Maintain a safe environment. Offer choices of two items. Evaluate medication regimen.Review of the Interdisciplinary Care Plan (ICP) revealed that there was a ICP dated 7/23/25 with a focus on behavior expression such as wandering, non-compliance with safety education, not utilizing the call bell and standing without assistance. There were no resident specific interventions documented on the ICP to demonstrate how the facility was managing these behaviors. The interventions included the following: Document in the progress notes the intensity, duration or frequency of the behavior. Notify the physician immediate changes in behavior. Encourage participation in activities. Encourage participation in activities of daily living. Orient to surroundings. Administer medications as ordered by the physician.Review of the Physician's orders (PO) dated 8/27/25 indicated that Zoloft was increased to 50 mg one tablet every day at bedtime.Review of the PO dated 8/27/25 reflected an order for Xanax 0.25 mg every 12 hours as needed for 14 days for anxiety disorder.Review of the psychiatric medical evaluation dated 9/3/25, indicated that Resident #37 had the diagnoses of anxiety and dementia. The psychiatrist lists the behaviors as anxiety, restlessness, trying to stand up from the wheelchair and wandering looking for their daughter. The psychiatrist documented that these behaviors occurred after dinner. The psychiatrist indicated that the antidepressant medication Zoloft 25 mg was being given to the resident for anxiety and restlessness. The documentation also indicated that the resident was to be given Xanax 0.25 as needed for 14 days for anxiety on 8/27/25 and discontinued on 9/10/25. There were no documented interventions on the behavior ICP or dementia ICP that specifically addressed behaviors such as wandering, pacing, trying to stand up from the wheelchair prior to administration of psychoactive medications.On 9/12/2025 at 11:06 AM, the surveyor interviewed the activities assistant director (AAD) who stated that new residents were assessed within 5 days of admission, quarterly and annually. She stated that these assessments were important to perform to assure that all residents activities need, wants and interest were reviewed. She added that these assessments assured that residents psychosocial needs were met. She explained that Resident 37 was encouraged to participate in sensory group activities which were held at 1:30 PM every day. This activity included music, story time, domestic chores such as folding. The AAD stated that she was not aware that the resident had sundowning issues in the evening hours and was not sure if the staff were supposed to let her know. When the surveyor asked the AAD if the nurse should have told her that the resident was a sundowner or had specific behaviors in the evening, she stated that she wasn't sure. She stated she only had access to the progress notes and didn't have access to the care plan. She stated that the Social Worker (SW) was taking care of updating the care plan because the Director of SW was out on leave. She stated that if the resident was experiencing behaviors later in the day, then it would have been important to have a ICP with interventions that were specific for the resident at the time of the day to address the behaviors. On 9/12/2025 at 11:18 AM, the surveyor interviewed the Director of Social Services (DSW) who stated that if Resident #37 was experiencing behaviors such as sundowning, pacing or wandering, the staff should have been trying non-pharmacological approaches to the behaviors before trying psychotropic medications. The SW reviewed the activities notes and admitted that there was no documentation regarding the residents' behaviors or any specific activities that were being offered to the resident to manage the behaviors. The surveyor asked the SW regarding dementia care plans and activities care plans and the SW stated that all resident specific interventions related to behaviors should have been addressed in the ICP. The DSW confirmed that there were no non-pharmacological interventions addressed in the resident's care plan for the listed behaviors. On 9/12/2025 at 12:10 PM, the surveyor interviewed the DSW, Director of Nursing (DON) and Assistant Administrator (AA) who all confirmed that there were no documentations in Resident #37's medical record that indicated non-pharmacological interventions were initiated prior (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to start of psychotropic drugs. The SW also confirmed that the ICP did not address activities or resident specific intervention for the dementia care plan.On 9/16/2025 at 10:09 AM, the surveyor interviewed the LPN/UM who reviewed the progress notes in the presence of the surveyor and agreed that there were no nursing notes prior to 7/9/25 which addressed resident specific behaviors or attempted interventions to manage the behaviors before starting the resident on the psychotropic medication Zoloft. She confirmed that there should have been documented non-pharmacological approach to effectively manage the resident's behavior of agitation or wandering. She also agreed that the resident's care plan did not address any non-pharmacological interventions that were attempted before starting the psychoactive medication Zoloft. The LPN/ UM confirmed that there was no documentation in the MAR for behavior monitoring before starting the resident on a psychoactive medication or after the resident started on a psychoactive medication. She stated that they dropped the ball on that one.On 9/16/2025 at 12:45 PM, the surveyor interviewed the medical director (MD) who stated that it was nursing 101 that the nursing staff would try non-pharmacological interventions in an attempt to manage behaviors prior to starting the resident on a psychotropic medication. The facility policy dated 4/21/25 and titled, Psychotropic Drugs indicated that it was the facility policy that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition diagnosed and documented in the clinical record. Residents who use psychotropic drugs receive a gradual dose reduction, behavior interventions, unless clinically contraindicated. The policy specified that the IDT will implement non-pharmacological approaches designed to meet the individual needs of each resident by way of a personalized care plan. The facility policy dated 4/21/25 and titled, Dementia Care Planning indicated that the facility would provide person-centered, dignified and safe care for residents living with dementia. All residents with dementia will have a comprehensive care plan developed, implemented and reviewed regularly. Care planning would include a personal history and interest, communication strategies, environmental modifications, triggers and calming techniques, nutritional and hydration support and medication review and management. The policy also indicated that the facility would use non-pharmacological interventions as a first line management of behavior issues. The facility would provide meaningful engagement and activities tailored to cognitive levels and interest. Document all interventions and updates.N.J.A.C. 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to accurately code a resident's oxygen (O2) administration on the quarterly Minimum Data Set (MDS) an assessment tool for 1 of 24 residents (Resident #9) reviewed and was evidenced by the following:Review of the Face Sheet (admission summary) indicated that Resident #9 was admitted to the facility with the diagnoses that included but was not limited to pneumonia (respiratory infection) and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care dated 8/15/25 indicated that Resident #9 scored an 8/15 on the Basic Interview for Mental Status (BIMS) which indicated moderate impairment of cognition. The MDS also reflected that Resident #9 required moderate assistance with all aspect of activities of daily living. The MDS did not reflect that the resident was being administered O2.On 9/11/2025 at 10:50 AM, during initial tour, the surveyor observed Resident #9 lying in bed on O2 at 2 liters by way of (via) nasal cannula (tubing that delivers O2 through the resident's nares). The surveyor was unable to interview the resident at this time because the resident was sleeping. The surveyor did not observe that the resident was short or breath or having difficulty breathing.The surveyor reviewed the residents EMR which revealed the following information:A review of the physician's orders (PO) dated 5/27/25, reflected a PO to administer O2 at 2 liters via nasal cannula as needed (prn) for pulse oximetry (measures amount of O2 in the blood) less than 91% (percent) on room air or visible shortness of breath. A review of quarterly MDS with an assessment reference date of 8/15/25, reflected that the resident was not administered O2. The surveyor reviewed the nursing progress note date 8/14/25 which indicated that the resident in fact was administered O2 at 2 liters. On 9/17/2025 at 9:50 AM, the surveyor interviewed the MDS Registered Nurse (MDS/RN) Coordinator who explained that the resident's quarterly MDS dated [DATE], had a look back was to 8/2/25. The MDS/RN confirmed that the documentation in the progress notes indicated that the resident received O2 on 8/14/25. The MDS Coordinator stated that the MDS had to be modified to include that the resident was on O2 at the time the MDS was completed. The MDS/RN stated that this was an error in documentation.A review of the facilities undated policy titled, MDS Coordinator Policy indicated that the Resident Assessment Instrument (RAI) assist skilled nursing facility staff to consistently and accurately gather information regarding residents' strength which provides the foundation for an individual interdisciplinary plan of care. The MDS Coordinator conducts a comprehensive assessment of residents to determine their healthcare needs, functional ability and psychosocial status. To ensure that the MDS is accurately completed to reflect each resident's clinical status.N.J.A.C 8:39-33.2 (d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, interview, and review of pertinent facility documentation, it was determined that the facility failed to implement a comprehensive, person-centered care plan (CPCCP) for pain that was consistent with professional standards of practice and included measurable objectives and timeframes to meet a resident's medical needs. This deficiency was identified for 1 of 1 resident (Resident #129) reviewed for pain.This deficient practice was evidenced by the following: On 09/11/2025 at 10:42 AM, the surveyor observed Resident #129 in their bedroom, lying in bed with the head of the bed elevated to approximately 45 degrees. The resident reported having undergone surgery on their lower right leg on 09/04/2025, including a skin graft (a medical procedure where healthy skin is removed from one area of the body and replaced to another area) for a painful wound in that area. The resident stated that he/she had received pain medication at approximately 6:00 a.m. and were planning to ask the nurse for additional medication for their lower right leg later. According to the admission record, Resident #129 was admitted to the facility with diagnoses including, but not limited to, atherosclerosis with ulceration to right lower leg (a condition where narrowed or blocked arteries have poor blood flow, resulting in formation of open sores), and pain in right leg. A review of Resident #129's annual Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 07/22/2025, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review of Section J: Health Conditions revealed that the resident receives as-needed pain medication and non-medication interventions for pain management. A review of Resident #129's physician orders (PO), dated as of 09/09/2025, included the following PO for oxycodone 5 milligrams (mg) tablets by oral route every 6 hours as needed for severe pain, and PO dated 09/10/2025 for acetaminophen extra strength 500 mg tablet give 2 tablets (1000 mg) by oral route every 6 hours as needed for moderate pain and acetaminophen 325 mg give 2 tablets (650 mg) by oral route every 4 as needed for mild pain. Resident #129 did not have a Comprehensive Person-Centered Care Plan (CPCCP) for pain to review. During an interview with the surveyor on 09/15/2025 at 12:10 PM, the Assistant Licensed Nursing Home Administrator stated that Resident #129 was admitted to the hospital from the facility in 08/2025 and returned on 09/09/2025. She stated that the resident had a CPCCP for pain prior to hospitalization, but she was not sure why a CPCCP for pain was not in place upon the resident's return. She acknowledged that the resident should have had one in place. The facility was unable to provide a policy regarding the development of a CPCCP. NJAC 8:39-11.2(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and review of medical records and other pertinent facility documentation it was determined that the facility failed to update and revise a resident's Interdisciplinary Care Plan (ICP) to accurately reflect the care for 1 of 24 residents (Resident #2) and was evidenced by the following: Review of the Face Sheet (admission summary) indicated that Resident #2 was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease, heart failure and diabetes mellites (DM).Review of the quarterly Minimum Date Set (MDS) an assessment tool that facilitates a resident's care dated 8/4/2025, indicated that Resident #2 had a score of 8/15 on the Brief Interview for Mental Status (BIMS) which indicated that the resident had moderate cognitive impairment. The MDS reflected that the resident required maximum assistance with activities of daily living.On 9/11/2025 at 10:54 AM, the surveyor observed Resident #2 sitting in the dayroom. The resident was very pleasant and well dressed. The surveyor observed that the resident had edema (swelling) of the lower extremities and was wearing compression stockings (stocking that manage circulatory issues and swelling). The resident was interviewed at the time and was unable to provide the surveyor details about the compression stocking. The surveyor reviewed the residents electronic medical record which revealed the following information:Review of the Physician's Order (PO) dated 1/29/2025, reflected an order to apply knee high (compression stocking) in the AM and remove at night (hs).Review of the Treatment Administration Record (TAR) for September 2025, reflected that the nurses were signing the TAR that they applied the compression stocking in the AM and removed them at hs.Review of the PO dated 12/10/2024, reflected that the resident was ordered the antidiuretic medication Furosemide 20 mg 1 (one) tablet daily and then subsequently discontinued. Review of the Resident #'2 Comprehensive Interdisciplinary Care Plan (ICP) dated 3/02/2020 and reviewed 8/4/2025, reflected that Resident #2 had decreased cardiac output and would be free of complications such as edema, fluid overload and shortness of breath. The ICP indicated that the resident was still on the medication Furosemide and there was no documentation that the resident was to wear compression stockings for edema management.On 9/15/2025 at 10:35 AM, Resident #2 was observed lying in bed. The resident was sleeping at this time, and the surveyor was unable to interview. The resident had compression stockings on the bilateral lower extremities. The surveyor interviewed the primary care Certified Nursing Assistant (CNA) who stated that compression stockings were applied every morning and removed at night for edema of the lower extremities.On 9/15/2025 at 10:54 AM, the surveyor interviewed the primary care Licensed Practical Nurse (LPN) who stated that Resident #2 had non-pitting (indentation) edema of the lower extremities and that the edema was chronic (persisting for a long time). She reviewed the resident's ICP in the presence of the surveyor and confirmed that the ICP reflected that the resident was on an antidiuretic medication even though there were no orders for diuretic medications. The LPN also stated that the compression stockings should be on the ICP as an intervention to reduce the resident's edema. She explained that the residents ICP should be resident specific to describe a resident's condition in real time. The LPN added that the Unit Manager was responsible to update residents ICPs. The LPN reviewed the resident's ICP and stated that the compression stocking should be a part of the ICP, and that the resident was not on a diuretic medication since starting on hospice.On 9/15/2025 at 11:06 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who reviewed Resident #2's ICP and confirmed that the compression stockings should be documented on the ICP and that the ICP should have been updated to reflect that. She also confirmed that the diuretic medication should have been removed from the ICP. On 9/17/2025 at 9:24 AM, the surveyor interviewed the Assistant Licensed Nursing Home Administrator and the Director of Nursing who both confirmed that the ICP should have been revised and updated to include the resident's compression stockings and discontinuation of the diuretic (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication Furosemide. The undated facility policy titled, Interdisciplinary Care Plans indicated that the care plan shall be designed to meet the resident's medical, nursing and psycho-social needs as identified in the comprehensive assessment. The ICP will be periodically reviewed and revised after each resident's annual assessment, quarterly review and upon significant change in condition. The care plan shall also be updated as warranted by a change in medication or treatments or other changes in condition.NJAC 8:39-11.2(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, interview, and pertinent facility documentation, it was determined that the facility failed to ensure that the resident's environment was free of possible hazards. This deficiency was identified in 1 of 2 residents (Resident #128) reviewed for accidents.This deficient practice was evidenced by the following: On 09/15/2025 at 11:20 AM, the surveyor reviewed the facility's accident investigation for Resident #128's near-fall incident that occurred on 10/11/2024. The identified contributing factor was a broken right halo bar (a safety and mobility device attached to the resident's bed) that failed to lock into place. Measure to prevent recurrence was notifying the maintenance department. On 09/15/2024 at 11:30 AM, the surveyor reviewed the facility's Housekeeping and Maintenance Request Forms for the period of 09/2024-10/2024. Logs showed two work requests for loose halo bars submitted by nursing: one on 09/25/2024 and another on 10/18/2025. However, there was no maintenance request submitted or completed on 10/11/2024 for Resident #128's halo bar following the near-fall incident out of bed. According to the admission record, the resident was admitted to the facility with diagnoses including, but not limited to, Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out simple tasks) and muscle weakness. A review of the resident's Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 10/30/2024, included a Brief Interview for Mental Status (BIMS) score of 2 out of 15, indicating severe cognitive impairment. The resident's comprehensive care plan, dated 09/18/2024, identified a focus area noting a high risk of falls and the need for preventative measures to reduce the likelihood of falls. During an interview with the surveyor on 09/15/2025 at 12:10 PM, the Assistant Licensed Nursing Home Administrator stated that Resident #128's halo bars were used as safety devices to help prevent falls and assist with mobility and repositioning in bed. She was unsure why maintenance did not complete a facility-wide audit of halo bars after Resident #128's near-fall incident, which involved the halo bars, to ensure all were functioning properly, noting that the maintenance director is no longer employed at the facility. A review of a facility policy dated 04/21/2025 titled, Quality of Life, revealed that, All staff shall care for our residents in a manner and in an environment that promotes maintenance and enhancement of each resident's quality of life. Environment - safe, comfortable, clean, orderly, home-like, appropriate linens, sound levels, ventilation, lighting, and proper care of personal belongings. NJAC8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, review of electronic medical records (EMR) and other pertinent facility documentation it was determined that the facility failed to document the administration of oxygen (O2) and failed to document the administration of O2 on the resident's Interdisciplinary Care Plan for 1 of 1 resident (Resident #9) reviewed for respiratory care and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. Review of the Face Sheet (admission summary) indicated that Resident #9 was admitted to the facility with diagnoses that included but were not limited to pneumonia (respiratory infection) and chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care dated 8/15/2025 indicated that Resident #9 scored an 8/15 on the Brief Interview for Mental Status (BIMS) which indicated moderate impairment of cognition. The MDS also reflected that Resident #9 required moderate assistance with all aspect of activities of daily living.On 9/11/2025 at 10:50 AM, during the initial tour, the surveyor observed Resident #9 lying in bed on oxygen (O2) at 2 liters by way of (via) nasal cannula (tubing that delivers O2 through the resident's nares). The surveyor was unable to interview the resident at this time because the resident was sleeping. The surveyor did not observe that the resident was short or breath or having difficulty breathing.The surveyor reviewed the residents EMR which revealed the following information:A review of the physician's orders (PO) dated 5/27/2025, reflected a PO to administer O2 at 2 liters via nasal cannula as needed (prn) for pulse oximetry (measures amount of O2 in the blood) less than 91% (percent) on room air or visible shortness of breath. A review of the Medication Administration Record (MAR) dated 9/11/2025, revealed that there was no documentation that the resident was administered O2 at 2 liters. The surveyor also reviewed the nursing progress notes dated 9/11/2025 and there was no documentation that the resident was administered O2.On 9/15/2025 at 11:25 AM, the surveyor observed Resident #9 in the room lying in bed sleeping and received O2 at 2 liters via nasal cannula. The resident was not able to be interviewed at that time.On 9/15/2025 at 11:42 AM, the surveyor interviewed the Registered Nurse (RN) who explained that she was new to the facility and that her previous nursing experience was from the acute care setting. The RN accompanied the surveyor to the resident's room and confirmed that the resident was being administered O2 at 2 liters via nasal cannula. The surveyor reviewed the MAR in the presence of the RN and the RN admitted that the O2 was not signed out in the MAR that the resident was receiving O2. The RN stated that she was not familiar with the LTC regulations and did not know that the nurses were responsible to sign out in the MAR that the resident was administered O2. She also stated that she worked on 9/12/2025 and that the resident was short of breath and required the PRN O2 on that day. She admitted that she applied the O2 as ordered by the physician, however, did not sign it out on the MAR when she administered the O2 on 9/12/2025.The surveyor reviewed the resident's MAR and progress notes dated 9/12/2025 and 9/15/2025, which revealed that there was no documentation that the resident received O2.Review of the Interdisciplinary Care Plan did not reveal that Resident #9 was being administered O2.On 9/15/2025 at 11:42 AM, the surveyor interviewed the Registered Nurse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit Manager (RN/UM) who stated that if a resident was on O2 all the time that was considered continuous and would require a physician's order. She added that if Resident #9 had a PO for prn O2, that would indicate that the resident would only be administered the O2 if the resident needed it. The RN explained that Resident #9 was currently being treated for pneumonia and needed the O2 at this time. She explained that the resident had a prn order for O2, and the nurses should be signing the O2 out on the MAR if the resident was administered O2. The RN/UM reviewed the MAR in the presence of the surveyor and confirmed that there were no nurse's signatures documented on the MAR that the resident was being administered O2. The RN/UM also reviewed the residents ICP and confirmed that there was no documentation on the care plan that the resident was on O2 continuously or intermittently.On 9/17/2025 at 9:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated that if a resident was prescribed O2 that the O2 should have been care planned and that the nurses were responsible to sign out the O2 on the MAR when administered.On 9/17/2025 at 9:25 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the administration of O2 should have been care planned for Resident #9 and that the nurses were responsible to sign out the O2 when it was administered to Resident #9.The facility policy dated 4/21/25 and titled, Oxygen Administration indicated that documentation details of emergency, resident condition, oxygen administered, SpO2 testing and the residents' response to therapy.The facility undated policy titled, Interdisciplinary Care Plans indicated that the care plan shall be designed to meet the resident's medical, nursing and psycho-social needs as identified in the comprehensive assessment and will include measurable time frames. The care plan shall also be updated as warranted by a change in medications or treatments or other changes in condition. The resident's care plan should address needs or care and be appropriate to the individual.NJAC 8:39-19.4(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and review of the medical record and other facility documentation, it was determined that the facility failed to a.) develop an individualized comprehensive assessment and Care Plan (CP) with resident specific interventions to address dementia care, and b.) follow the facility policy for dementia care. This deficient practice was identified for Resident #37, 1 of 1 resident reviewed for dementia care and was evidenced by the following:Review of the resident Face Sheet (admission summary) indicated that Resident #37 was admitted to the facility with diagnoses that included but were not limited to dementia with other behavior disturbance, anxiety disorder, hypothyroidism and hypertension.Review of the quarterly Minimum Date Set (MDS) an assessment tool that facilitates a resident's care dated 8/15/2025, indicated that Resident #37 had short and long-term memory deficits and was severely impaired with decision making. The MDS also indicated that the resident required moderate assistance with activities of daily living and did not exhibit behaviors.On 9/11/2025 at 11:15 AM, the surveyor observed Resident #37 sitting quietly in the hallway in front of the nurse's station. The resident was in no distress, clean and dressed appropriately. The resident was unable to be interviewed due to cognitive deficits.On 9/12/2025 at 10:22 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who told the surveyor that Resident #37 required assistance with washing and dressing. The CNA also stated that Resident #37 was confused. She explained the resident required assistance with tray set up but was able to feed themselves and did not have behaviors that she was aware of. On 9/12/2025 at 10:27 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #37 required supervision and direction due to the resident's confusion. She stated that the resident had sundowning (a period of increased confusion, agitation, and behavioral changes that often occurs in the late afternoon and evening in people with dementia) and paced the hallways at times in the wheelchair. She explained that the resident was redirected with guiding, food and toileting. She stated that the resident required Xanax (antianxiety medication) at times due to being restless, yelling and trying to stand up. She stated that the resident was given a Xanax but not all the time. She stated that the staff would try to bring the resident to activities, but the resident at times would not participate. On 9/12/2025 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manage (LPN/UM) who stated that Resident #37 had confusion and was very calm in the morning but restless in the afternoon and early evening. She stated that the resident paced in the wheelchair and that they usually had to have a staff member sit with the resident. She stated that the activities department would try to read with the resident, take the resident outside, sit with the resident, provide snacks or they would let the resident fold clothes as a diversion.Review of the Interdisciplinary Care Plan (ICP) revealed that there was a ICP dated 5/12/2025 with a focus on Dementia. There were no resident specific interventions to demonstrate how the facility was managing the resident's dementia or behaviors associated with dementia. The interventions included the following: Use simple words or instructions. Maintain a safe environment. Offer choices of two items. Evaluate medication regimen.Review of the psychiatric medical evaluation dated 9/3/2025, indicated that Resident #37 had diagnoses of anxiety and dementia. The psychiatrist lists the behaviors as anxiety, restlessness, trying to stand up from the wheelchair and wandering looking for his/her daughter. The psychiatrist documented that these behaviors occurred after dinner. There were no resident specific interventions documented on the ICP to address triggers or calming techniques used to manage or address the resident's dementia or behaviors associated with dementia. There were no person-centered interventions documented that specifically addressed these behaviors such as sundowning, wandering, pacing, trying to stand up from the wheelchair. On 9/12/2025 at 11:06 AM, the surveyor interviewed the activities assistant director (AAD) of the recreation department who stated that new residents were assessed within 5 days of admission, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quarterly and annually. She stated that these assessments and reviews were important to perform to assure that all residents activity needs, wants and interests were reviewed to assure that the residents were getting their psychosocial needs met. She stated that Resident #37 was encouraged to participate in sensory group activities which was held at 1:30 PM every day. This activity included music, story time and domestic chores such as folding. The AAD stated that she was not aware that the resident had sundowning issues and was not sure if the staff were supposed to let her know. When the surveyor asked the AAD if the nurse should have told her that the resident was a sundowner or had specific behaviors in the evening, she stated that she wasn't sure. She stated that she only had access to the progress notes and didn't have access to the ICP. She stated that the Social Worker (SW) was taking care of updating the care plan updating and the Director of Social Work was out on leave. She stated that if the resident was experiencing behaviors later in the day, then it would have been important to have a ICP with interventions that were specific for the resident at the time of the day to address the behaviors. On 9/12/2025 at 11:18 AM, the surveyor interviewed the Director of Social Services (DSW) who was employed in the facility for 11 years. The DSW stated that if Resident #37 was experiencing behaviors such as sundowning, pacing or wandering the staff should have been trying non-pharmacological approaches to manage the behaviors. The SW reviewed the activities notes and admitted that there was no documentation in the progress notes or on the Dementia ICP regarding the residents' behaviors or any specific activities that were being offered to the resident to manage the behaviors. The surveyor asked the SW regarding dementia care plans and activities care plans and the SW stated that all resident specific interventions related to behaviors should have been addressed in the CP. On 9/12/2025 at 12:10 PM, the surveyor interviewed the DSW, Director of Nursing (DON) and Assistant Administrator (AA) who all confirmed that there were no documented interventions on the ICP to address activities or resident specific behavior interventions in the dementia care plan.On 9/16/2025 at 10:09 AM, the surveyor interviewed the LPN/UM who reviewed the ICP in the presence of the surveyor and stated that they dropped the ball on that one and there were no documented interventions to address the resident specific behaviors. The facility policy dated 4/21/2025 and titled, Dementia Care Planning indicated that the facility would provide person-centered, dignified and safe care for residents living with dementia. All residents with dementia will have a comprehensive care plan developed, implemented and reviewed regularly. Care planning would include a personal history and interest, communication strategies, environmental modifications, triggers and calming techniques, nutritional and hydration support and medication review and management. The policy also indicated that the facility would use non-pharmacological interventions as a first line management of behavior issues. The facility would provide meaningful engagement and activities tailored to cognitive levels and interest. Document all interventions and updates.N.J.A.C 8:39-45.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and review of pertinent facility documents, it was determined that the facility failed to a.) ensure the Infection Preventionist (IP) was present for quarterly Quality Assurance and Performance Improvement (QAPI) meetings, and b.) included as a member of the Quality Assessment and Assurance (QAA) Committee. This deficient practice was identified by the following: On 09/15/2025 at 12:35 PM, the surveyor interviewed the IP who stated that she had worked at the facility for the past two and a half years in her current role and had never attended a QAPI meeting. She reported that she provided infection control information to the Director of Nursing (DON), who presented it during the QAPI meetings. On 09/17/2025 at 10:14 AM, the surveyor interviewed the Assistant Licensed Nursing Home Administrator (ALNHA) who stated that the IP did not attend QAPI meetings and was not a member of the QAA committee. The Director of Nursing (DON) presents infection control information during the QAPI meetings. On 09/16/2025 at 12:02 PM, the surveyor reviewed the facility's 2025 quarterly QAPI attendance sheets for meetings that were held on 01/28/2025, 04/25/2025, and 07/29/2025, as well as the list of QAA committee members. The Infection Preventionist (IP) did not attend any of the QAPI meetings and was not listed as a member of the QAA committee. A review of a facility policy dated 04/01/2025 titled, Quality Assurance and Performance Improvement (QAPI), revealed that, It is the policy of [NAME] Garden to develop a QAPI plan in accordance with Federal Guidelines to describe how the facility will address clinical care, resident quality of life and residents' choice and is based on the scope and complexity of services defined by the Facility Assessment. NJAC 8:39-33.1(a)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interviews, record reviews, and a review of pertinent facility documentation, it was determined that the facility failed to consistently implement an Antibiotic Stewardship Program (ASP), a program designed to improve clinical outcomes and reduce harm by promoting the appropriate use of antibiotics and monitoring their use, in collaboration with the facility's consultant pharmacist and medical director. This deficiency was identified in 1 of 1 resident (Resident #44) reviewed for antibiotic use.The deficient practice was evidenced by the following: On 09/15/2025 at 1:00 PM, the surveyor reviewed the facility's monthly antibiotic roster for 08/2025, which is used to monitor all residents receiving antibiotics. The roster, provided by the Infection Preventionist (IP), did not include Resident #44, who had received intravenous (IV) (a method that allows the medication to enter the bloodstream quickly and work faster) antibiotics during 08/2025. According to the admission record, Resident#44 was admitted to the facility with diagnoses including, but not limited to, infection following a procedure at the surgical site on the lumbar spine, and Methicillin-Resistant Staphylococcus Aureus (MRSA) infection (a type of bacteria that causes infections and is resistant to many common antibiotics). A review of Resident's #44 admission Minimum Data Set (MDS), an assessment tool used to facilitate care management, dated 08/06/2025, included a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review of Section 0: Special Treatments, Procedures, and Programs revealed that the resident had received IV medication. Resident's #44 comprehensive care plan, dated 07/28/2025, included a care area indicating that the resident was receiving IV antibiotic therapy for an MRSA wound infection. A review of Resident #44's Physician Orders (PO), dated 08/03/2025, included an order for cefazolin 2 grams in 50 milliliters of dextrose intravenous piggyback (IV medication diluted in a carrier fluid to treat bacterial infections), to be infused by IV every 8 hours for a total of 142 doses. During an interview with the surveyor on 09/15/2025 at 12:35 PM, the Infection Preventionist (IP) stated that, as part of her daily infection control tasks, she keeps detailed records for each resident receiving antibiotics, including the type of infection, lab results, start and end dates, and the prescribed antibiotic. She stated that she was not sure what specific criteria the facility uses to diagnose infections and would need to follow up to determine that information. She further stated that she is not familiar with established clinical criteria used to identify infections in long-term care facilities. During an interview with the surveyor on 09/16/2025 at 11:20 AM, the Assistant Licensed Nursing Home Administrator stated that she was unsure of the clinical criteria the facility used to identify infections. She also indicated that if Resident #44 had received IV antibiotics, the resident should have been included on the 08/2025 monthly antibiotic roster. During an interview with the surveyor on 09/16/2025 at 11:32 AM, the facility's Pharmacist Consultant stated that the facility uses the Situation, Background, Assessment, Recommendation (SBAR) form as the primary tool for tracking and managing antibiotic usage. During an interview with the surveyor on 09/16/2025 at 12:58 PM the facility's Medical Director stated that the facility uses the Situation, Background, Assessment, Recommendation (SBAR) form as the primary tool for tracking and managing antibiotic usage. A review of the facility's policy dated 03/28/2025, titled, Antibiotic Stewardship Policy, revealed that, It is the policy of the facility to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The facility is committed to improving antibiotic prescribing practices and reducing inappropriate antibiotic use. A monthly infection control report will be completed, including both a quantitative and qualitative rationale for why the antibiotic was needed, the outcome of its effectiveness in treating the infection, and any associated adverse side effects. N.J.A.C. 8:39-19.4(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure the Infection Preventionist (IP) actively performed responsibilities in accordance with the facility designated role implementing programs and activities to prevent and control infections.The deficient practice was evidenced by the following: During an interview with the surveyor on 09/15/2025 at 12:35 PM, the IP stated that she was not sure what specific criteria the facility used for diagnosing infections and would need to follow up to determine that information. She further stated that she is not familiar with established clinical criteria used to identify infections in long-term care facilities. The IP also reported that she is not involved in the facility's water management or treatment plan, explaining that those responsibilities are handled by the maintenance department. Additionally, she stated that she does not conduct regular surveillance in the kitchen or laundry areas and only enters those areas if she needs something. During an interview with the surveyor on 09/16/2025 at 11:20 AM, the Assistant Licensed Nursing Home Administrator stated that she was unsure what clinical criteria the facility used to identify infections. She further stated that the IP does not conduct surveillance in the kitchen or laundry areas. Instead, she does weekly rounds throughout the facility every Monday with the Maintenance Director. A review of the facility's policy dated 03/28/2025, titled, Infection Control Rounds, revealed that, the objective of infection control round is to evaluate compliance with infection control policies and procedures throughout the facility, and data collected during rounds shall be utilized for educating staff and improving resident care and facility practices. NJAC 8:39-19.1(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Garden Nursing and Rehabilitation Center	1579 Old Freehold Road Toms River, NJ 08753

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, it was determined that the facility failed to ensure that the pneumococcal vaccination was offered to all residents upon admission to the facility to prevent incidence of pneumonia for 1 of 5 residents (Resident # 87) reviewed for immunization administration. This deficient practice was evidenced by the followingDuring the initial tour of the facility on 09/11/2025 at 10:21 AM, Resident #87 was observed seated in a wheelchair in their bedroom. A review of Resident #87's admission Record revealed that the resident was admitted to the facility with diagnosis which included, but were not limited to, displaced fracture of the left lower leg and encounter for orthopedic aftercare.A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/22/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS identified under Section O that the Pneumococcal Vaccine was offered but declined. A review of Resident #87's Immunization Consent form, dated 7/16/2025, identified under Pneumonia Vaccine: (checked) I do want [resident name] to be given the pneumonia vaccine. When the surveyor requested a printed copy of Immunization form, it was observed that a handwritten year was entered into the line that stated: [Blank] has received the Pneumonia previously on 2024, which was not identified in the electronic medical record. A review of Resident #87's Nursing Immunization Record form, created on 7/16/2025 and completed on 7/2/25, identified under Pneumonia Vaccine: Is the resident's Pneumococcal vaccination up to date? and Yes is checked. On 9/16/2025 at 9:18 AM, during an interview with the surveyor, the Infection Preventionist (IP) advised that she was responsible for overseeing the immunization consents. When asked for documentation of Resident #87 pneumococcal vaccination, the IP responded that the resident was admitted for short term rehabilitation and that the pneumococcal vaccine is only admitted to long term care residents. On 9/12/2025 at 9:54 AM, during an interview with the surveyor the Director of Nursing (DON) confirmed that all residents, both long term care and short-term rehabilitation should be offered the pneumonia vaccine and that it was one of the questions asked during admission. On 9/12/2025 at 11:26 AM, during an interview with the surveyor the DON, in the presence of the Licensed Nursing Home Administrator confirmed that all residents, both long term care and short-term rehabilitation should be offered the pneumonia vaccine.A review of the undated facility provided document Prevention and Control of Nosocomial Pneumonia Pneumococcal Vaccine revealed the following: The facility shall offer the pneumococcal vaccine to every resident upon admission who has not had the vaccine unless medically contraindicated or refused by the resident [.] Consent or refusal for the initial and second shall be signed by the resident or family member after receiving documented education on the risks and benefits of the vaccination.NJAC 8:39-19.4 (h) (i)